Name (Last, First MI) Generation (Sr., Jr., I, II, etc)

Patient ID# (Assigned by OCHD)

DOB

Onslow County Health Department (OCHD)

Travel Clinic
Patient Questionnaire

ITINERARY. *List the countries/cities you will be visiting. The United States will be your country of origin.*			
Country		City	
Country		City	
Country		City	

Leaving the United States on this date:		Returning to the United States on this date:	

Will the trip be *(check all that apply)*?	☐ Urban	☐ Rural	☐ Both

Accommodations *(check any that apply):*	☐ Hotel	☐ Camp/Tent	☐ Dormitory	☐ Ship	☐ Private Residence/Home

ALLERGIES / MEDICAL CONDITIONS			
1. Do you have any Medicine allergies?	☐ No	☐ Yes, if yes list below.	
2. Are you pregnant or contemplating pregnancy?	☐ No	☐ Yes	☐ Not Applicable
3. Are you breastfeeding?	☐ No	☐ Yes	☐ Not Applicable
4. Have you had any severe reactions to past vaccines?	☐ No	☐ Yes, if yes list below.	
5. List all medications you are currently taking, either prescriptions or over-the-counter (attach list if needed):			
6. Do you have any medical conditions, such as diabetes, heart disease, or lung disease? If so, explain below:			

IMMUNIZATION RECORD

NOTE BELOW ANY DISEASES YOU HAVE HAD WITH DATES OR VACCINATIONS WITH THEIR DATES.
BRING YOUR IMMUNIZATION RECORD WITH YOU TO YOUR APPOINTMENT

IMMUNIZATION HISTORY	DATE	DATE	DATE	HAVE YOU HAD THIS DISEASE? IF SO, STATE YEAR.	UNKNOWN
HEP A (2 DOSES)					☐
HEP B (3 DOSES)					☐
HEP A/B (3 DOSES)					☐
INFLUENZA					☐
MMR					☐
MENINGOCOCCAL					☐
PNEUMOCOCCAL POLYSACCHARIDE					☐
POLIO BOOSTER					☐
RABIES					☐
TD/TDAP					☐
TYPHOID					☐
VARICELLA					☐
YELLOW FEVER					☐
JAPANESE ENCEPHALITIS					☐

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ANSWER THE FOLLOWING QUESTIONS BY CHECKING YES, NO OR UNKNOWN			
1. Do you have sensitivity to sodium chloride, sorbitol or have been diagnosed with multiple sclerosis (MS)?	☐ No	☐ Yes	☐ Unknown
2. Are you allergic to gelatin?	☐ No	☐ Yes	☐ Unknown
3. Do you have sensitivity to yeast extract, casein, dextrose, galactose, sucrose, ascorbic acid, amino acids, lactose, or magnesium stearate?	☐ No	☐ Yes	☐ Unknown
4. Do you have an allergy to natural latex rubber?	☐ No	☐ Yes	☐ Unknown
5. Do you have sensitivity to protamine sulfate?	☐ No	☐ Yes	☐ Unknown
6. Do you have an allergy to thimerosal?	☐ No	☐ Yes	☐ Unknown
7. Do you have an allergy to yeast?	☐ No	☐ Yes	☐ Unknown
8. Do you have an allergy to neomycin?	☐ No	☐ Yes	☐ Unknown
9. Are you allergic to eggs or chicken protein?	☐ No	☐ Yes	☐ Unknown
10. Are you allergic to processed bovine gelatin, chlortetracycline, or amphotericin B?	☐ No	☐ Yes	☐ Unknown
11. Do you have sensitivity to phosphate or glutamate?	☐ No	☐ Yes	☐ Unknown
12. Are you immunosuppressed due to HIV, leukemia, lymphoma, thymic disease, generalized malignancy, corticosteroid therapy, alkylating drugs, antimetabolites, or radiation?	☐ No	☐ Yes	☐ Unknown
13. Do you have a history of thymus disease, myastenia gravis, DIGeorge syndrome or thymoma?	☐ No	☐ Yes	☐ Unknown
14. Have you had removal of part of your intestine?	☐ No	☐ Yes	☐ Unknown
15. Are you taking sulfonamides or antibiotics?	☐ No	☐ Yes	☐ Unknown
16. Are you currently experiencing an acute gastrointestinal illness?	☐ No	☐ Yes	☐ Unknown
17. Do you have a history of Guillian-Barre Syndrome?	☐ No	☐ Yes	☐ Unknown
18. Have you had a past reaction to pertussis (whooping cough) vaccine?	☐ No	☐ Yes	☐ Unknown
19. Do you have a history of a progressive neurologic disorder, uncontrolled epilepsy, or progressive encephalopathy?	☐ No	☐ Yes	☐ Unknown
20. Do you have thrombocytopenia?	☐ No	☐ Yes	☐ Unknown
21. Do you desire anti-malarial medications?	☐ No	☐ Yes	☐ Unknown
22. Do you desire a prescription for the treatment of Traveler's Diarrhea?	☐ No	☐ Yes	☐ Unknown

Patient's Signature: _____ Date: _____

Reviewed by Signature: _____ Date: _____

RETURN COMPLETED FORM ONE (1) WEEK PRIOR TO SCHEDULED APPOINTMENT BY:

(910) 347-4246 (FAX)
or
Mailing/Hand Delivering to:

Onslow County Health Department
ATTN: Immunization Travel Clinic
612 College St.
Jacksonville, NC 28540